REPORT OF THE

OFFICE OF THE AUDITOR GENERAL

TO THE

JOINT LEGISLATIVE AUDIT COMMITTEE

236.3

A REVIEW OF THE PRACTICES OF THE BOARD OF MEDICAL QUALITY ASSURANCE AND THE SERVICES PROVIDED TO THAT BOARD BY THE OFFICE OF THE ATTORNEY GENERAL

FEBRUARY 1976

Joint Legislative Audit Committee

OFFICE OF THE AUDITOR GENERAL

California Legislature

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February 18, 1976

The Honorable Speaker of the Assembly
The Honorable President pro Tempore of
the Senate
The Honorable Members of the Senate and the
Assembly of the Legislature of California

Members of the Legislature:

Transmitted herewith is a review by the Office of the Auditor General of the practices of the Board of Medical Quality Assurance and the services provided that Board by the Attorney General.

This damning report on state regulation of physicians is an indictment of elected and appointed officials alike including the California Legislature, the Attorney General, the Director of Consumer Affairs, and the appointees of the medical discipline body created by the Legislature and appointed by the Governor of California. All have or may plea a shortage of funds, staff and an obvious deficiency in the regulatory laws. Such arguments are intolerable unless explicitly brought to the attention of the Legislature prior to the publication of this report.

It is shocking that ordinary physician negligence resulting in severe injury or death to the patient is not subject to regulation or discipline by the State of California.

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Defining the problem is often described as 90 percent of the solution: the remaining 10 percent is commended to the urgent attention of the Governor and the California Legislature.

The audit staff responsible for this report are Gerald A. Hawes, Robert J. Maloney, Thomas P. Callanan, Dore C. Tanner and Linda L. Huffman.

Respectfully submitted,

MIKE CULLEN, Chairman
Joint Legislative Audit Committee

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INTRODUCTION

In response to a legislative request, we have reviewed the activities of the Board of Medical Quality Assurance, formerly known as the Board of Medical Examiners.

Our first report on the Board, Number 236.1, issued in August 1975, addressed the issue of the role of the Board in processing allegations against physicians accused of violating the Medical Practice Act as stated in the Business and Professions Code. That report noted several deficiencies in the Board's disciplinary activities. These deficiencies were acknowledged by the staff of the Board and the Director of Consumer Affairs. The present report analyzes in greater detail the role of the Attorney General's Office in the disciplining of physicians and the statutory limitations as contained in present law governing physician negligence.

The report also contains recommendations which, if implemented, will result in the identification of additional physicians who may be practicing in an improper manner, and will provide for a more prompt disposition of disciplinary proceedings against physicians.

We received excellent cooperation from the Office of the Attorney General and the Board of Medical Quality Assurance. We also received excellent cooperation from the staff of the Department of Consumer Affairs.

In Assembly Bill 1XX, effective December 12, 1975, the Legislature determined that the public health required the establishment of procedures to assure the maintenance of high-quality medical practice. To assure this quality, the Legislature, in Assembly Bill 1XX, established a system of medical quality review committees under the jurisdiction of the Division of Medical Quality of the Board of Medical Quality Assurance.

Our Office will continue to monitor the efficiency and effectiveness of disciplinary actions of the Board to ensure that the public is protected. Field work for this review was completed January 9, 1976.

BACKGROUND

The Medical Injury Reform Act, Assembly Bill No. 1 (AB 1XX), as amended by Senate Bill No. 24 (SB 24XX), of the Second Extraordinary Session of the 1975 California Legislature, was enacted to help solve the medical malpractice insurance crisis. The legislation established malpractice insurance reforms and reorganized the Board of Medical Examiners.

The legislation changed the name of the Board of Medical Examiners to the Board of Medical Quality Assurance. The membership of the Board was increased from 11 to 19, and the Board's activities were assigned to three divisions: Medical Quality, Licensing and Allied Health Professions.

The seven member Division of Medical Quality has responsibility for:

- Reviewing the quality of medical practice carried out by physician and surgeon certificate holders under the jurisdiction of the Board
- Administering and hearing of disciplinary actions
- Carrying out disciplinary action appropriate to findings made by a medical quality review committee, a hearing officer, or the Division.

The Division of Licensing consists of seven members. In general, it has the responsibility for the licensing of physicians and suspending, revoking or limiting licenses and certificates upon order of the Division of Medical Quality.

The five-member Division of Allied Health Professions in general has responsibility for licensing and disciplining of non-physician certificate holders under jurisdiction of the Board.

The Board may employ investigators, legal counsel, medical consultants, and any such clerical assistance it deems necessary to enforce the law.

The Attorney General is to act as the legal counsel of the Board for any judicial proceeding and, at the Board's discretion, for administrative proceedings.

FINDINGS

THE FILING OF CHARGES BY THE OFFICE OF THE ATTORNEY GENERAL AGAINST PHYSICIANS SUSPECTED OF VIOLATING THE MEDICAL PRACTICE ACT HAS NOT BEEN ACCOMPLISHED IN A TIMELY MANNER AND HAS PERMITTED ALLEGED SERIOUS VIOLATORS OF THAT ACT TO CONTINUE THE PRACTICE OF MEDICINE DURING THIS LENGTHY PROCESS.

The Office of the Attorney General, Professional and Vocational Licensing Section, has not prepared accusations in a timely manner against physicians suspected of violating the Medical Practice Act. This has permitted suspected serious violators of the Act to continue practicing with unrestricted licenses. This occurred because of inadequate funding and delays in obtaining additional evidence, including expert witnesses.

Disciplinary actions against physicians are initiated by the Board of Medical Quality Assurance. The Board receives complaints against physicians from a variety of sources, including patients, hospitals, insurance company malpractice payment reports, police records and other physicians. Complaints are investigated by the Division of Investigation, a separate division within the Department of Consumer Affairs, which conducts investigations on behalf of the boards and bureaus within the Department. Following completion of the investigation and a determination by the Board that the alleged offense warrants discipline, the case is referred to the Attorney General's

Professional and Vocational Licensing Section. The prosecution of charges is conducted in a public hearing conducted by an administrative hearing officer, a Medical Quality Review Committee or the Division of Medical Quality Assurance.

By the time a case reaches the Attorney General, it has been judged by the Board and the Division of Investigation to be of sufficient severity to warrant disciplinary action. Evidence supporting the allegations is forwarded to the Attorney General's Office to enable it to substantiate the charges.

After the hearing is held, the discipline imposed may range from revocation of a physician's license to a probationary term or censure.

The Medical Practice Act prescribes how a physician will be licensed and gives the Board authority to monitor its licensees and to ensure that their professional conduct and the quality of their medical care meet the standards of the Act.

Since December 1973 the Professional and Vocational Licensing Section of the Attorney General's Office has a policy of requiring accusations on behalf of all boards and bureaus within the Department of Consumer Affairs to be completed within 30 days of their receipt. Our review has disclosed that the Attorney General has not met this self-imposed requirement.

The importance of moving swiftly against suspected serious violators of the Medical Practice Act cannot be overemphasized. Physicians are a special group whose improper activities can pose an immediate threat to the health and safety of the public. By not acting in a timely manner, physicians and surgeons are allowed to continue practice with unrestricted licenses.

Another reason for moving swiftly against suspected serious violators of the Act is the possibility that pertinent records and witnesses will be unavailable because of the passage of time. For example, a recent gross negligence and incompetence case was "no longer provable" because the bulk of the necessary X-rays no longer existed.

Delays in Filing Charges

The 205 cases involving alleged violations by physicians and surgeons referred to the Attorney General's Office before July 1, 1975 and still pending as of August 27, 1975 were reviewed. The Attorney General took more than 30 days to prepare formal charges in 90 percent of these cases. On 155 cases that have had charges filed as of September 15, 1975, the average length of time to prepare an accusation was 129 days. The number of days spent on the 50 cases not completed ranged from 81 days to 546 days as of September 15, 1975.

The longest time periods were spent on cases involving allegations of gross negligence and/or incompetence on the part of physicians.

Appendix I illustrates the number of days taken by the Attorney General's Office to prepare an accusation for the Board by type of violation and the number of days spent on accusations not completed as of September 15, 1975.

The reason cited by the Office of the Attorney General is the lack of sufficient funds and staff to handle the increasing number of cases being referred to its office by the boards and bureaus in the Department of Consumer Affairs. Additional funds for the Attorney General's Office have recently been approved by the Department. This will permit the increase of the legal staff available to process cases from 36 to approximately 42.

Another reason for the delays in preparing accusations is the need for additional information from the Board and the Division of Investigation. Additional information may include clarification of expert witnesses' statements and obtaining additional evidence.

Difficulties in Corroborating Physician Deficiencies

Obtaining expert testimony on alleged gross negligence and/or incompetence by physicians may delay the investigation and the prosecution of the case. Expert testimony must be used as a basis to discipline a doctor who might be practicing in an incompetent and/or gross negligent manner. We found examples of instances illustrating these situations. An example encountered by the Division of Investigation in securing

expert witnesses involved a physician's being investigated for alleged inadequate and inappropriate hospital records and being denied hospital privileges. The investigator interviewed a physician regarding the medical records of the subject. This physician told the investigator that he believes the subject is incompetent based on record keeping alone. However, the physician declined to give the investigator a declaration or state specifics regarding the charts he reviewed. Another physician told the investigator that the subject's records showed incompetence, but he would rather the investigator obtain an opinion from someone outside the area.

An example of the problems encountered by the Attorney General's Office in locating expert witnesses involved two physicians whose patient died during an elective sterilization surgery in November 1972 as a result of being blown up by gas used to expand her uterus. One of the physicians involved was the surgeon, the other the anesthesiologist. The surgeon was indicted by the local grand jury for involuntary manslaughter in early 1973. The anesthesiologist, because he was not monitoring the patient and was away from the operating room at the time of the patient's death, was also criminally indicted but charges were later dropped. The surgeon pleaded no contest to the charges and was placed on three years' probation. The Division of Investigation began its investigation of the case in December 1972. The case files on both physicians were forwarded to the Attorney General's Office in late 1974.

To date, no accusation against the physicians have been filed and both physicians are practicing medicine with an unrestricted license.

The Deputy Attorney General in charge of this case stated his work has been hampered by three factors:

- An inability to find expert witnesses willing to testify that the physicians' conduct was a gross departure from the normal practice of medicine
- The fact that evidence needed to prove the case against the physicians is currently tied up in a malpractice suit against the doctors brought by the patient's family
- The Deputy Attorney General's large caseload.

On the matter of expert witnesses involving this case, the deputy stated that two experts retained to testify against the physicians later declined to testify. He said he was not concerned about the length of time that had elapsed since the incident occurred because neither physician poses "that much of a threat to society". In addition, he noted that pressure on deputies to file cases often forces them to file the easy ones, cases that are clear-cut and easy to prove.

Another example involves a doctor whose administrative hearing was postponed for nearly 18 months because expert witnesses could not be secured. The doctor was under scrutiny by the Board because his malpractice insurance carrier had reported that he and two colleagues had been successfully sued for more than $600,000 for the death of the patient. The incident in question involved the physician's use, inside a patient's mouth, of a sterilizing solution normally limited to external

use. The Attorney General received the case in August of 1973 and filed charges two months later. The first expert witness scheduled to testify declined one day before the first hearing in July 1974. Another expert witness, who would be willing to testify that it was a substantial departure from normal standards of practice for the doctor to use the external sterilizing solution inside a patient's mouth, could not be found until June 1975.

Efforts by the Attorney General to secure a replacement witness from the same urban area in which the doctor in question practiced failed and the matter was postponed for nearly a year. Finally, a witness was secured from a community 100 miles away. The Deputy Attorney General in charge of prosecuting the case said the delay in locating an expert witness was due to pressure applied by the local medical society on potential witnesses against the accused physician. In this case, it took a year to obtain an expert witness who practiced in another community outside the influence of the accused physician's medical society.

The provisions of recently enacted legislation require the Attorney General's Office to file accusations within 30 days of the determination that grounds exist for filing suit. There currently exists no time limit on the Attorney General's Office to make a determination that grounds exist for disciplinary action. In addition, provisions of SB 24XX, which amended AB 1XX, allow the Board to use other legal counsel, if it desires, for administrative proceedings. The Department and its boards are not required to use the Attorney General in the preparation of accusations and preparation made in administrative hearings prior to AB 1XX and SB 24XX.

The Board's Responsibility

The Board of Medical Quality Assurance is the agency charged by law with protecting the public against unfit physicians. As such, it has the right to demand that the Attorney General's Office, when performing legal services for the Board, perform them promptly and in accordance with the Board's instructions.

CONCLUSION

In our judgment, the Professional and Vocational Licensing Section of the Office of the Attorney General has not prepared accusations against physicians suspected of violating the Medical Practice Act in a timely manner even though the continued practice of a serious violator can pose an immediate threat to the health and safety of the public.

RECOMMENDATIONS

We recommend that:

- The Attorney General's Office prepare accusations within the 30-day legal requirement as mandated by the Medical Injury Compensation Act, which became effective December 12, 1975 and the Office's self-imposed time limit of 30 days that has existed since December 1973.

- The Board of Medical Quality Assurance monitor the timeliness of the services provided by the Professional and Vocational Licensing Section of the Attorney General's Office in the future. If the timeliness of the legal service does not meet the 30-day limit, we recommend that the Board discontinue using the Attorney General's Office and obtain other legal counsel for administrative proceedings.

THE PRESENT STATUTE IS INADEQUATE TO PROTECT THE PUBLIC FROM PHYSICIANS WHOSE NEGLIGENCE MAY RESULT IN BODILY HARM OR DEATH.

The Board has been restricted from acting to assure the quality of medical treatment because of statutory limitations regarding acts of negligence. Section 2361 of the Business and Professions Code cites gross negligence as unprofessional conduct for licensees of the Board of Medical Quality Assurance. It also includes other acts such as moral turpitude and incompetence; however, it does not address other forms of negligence other than gross. Such a standard, as it relates to negligence, provides a very narrow legal criterion on which to file an accusation to discipline a licensed physician.

There are approximately 46,000 practicing physicians in California. In the six-year span between 1970 and 1975, there have been 15 cases resulting in disciplinary actions against physicians based on gross negligence, as shown in Table 1 below:

Table 1

Year	Number of Disciplinary Actions
1970	3
1971	2
1972	4
1973	2
1974	1
1975	3

There have been no disciplinary actions based on other forms of negligence. In the first quarter of 1975 there were 435 investigations of gross negligence and/or incompetence, yet in only three instances

throughout the year was disciplinary action taken against the licensee.

The Director of the Department of Consumer Affairs recommended that "gross" be deleted from Section 2361(b) and that "negligence" be sufficient as unprofessional conduct. Gross negligence has been defined as an extreme departure from the standard of practice of medicine. The Director stated that gross negligence requires a far more difficult burden of proof than negligence. Negligence already is defined as unprofessional conduct for engineers and architects licensed by their respective boards in the same department.

The only public member of the former Board of Medical Examiners, now the Board of Medical Quality Assurance, stated in a letter of September 4, 1975 that AB 1XX made virtually no change regarding the definition of unprofessional conduct. In the same letter, he stated to the author of AB 1XX, that without some broadening of the grounds for discipline, it is anticipated there will be no more weeding out of the poor practitioners after the enactment of the bill than had occurred before.

Cases of Negligence Outside the Board's Current Jurisdiction

A serious consequence of limiting the Board's jurisdiction to acts of gross negligence is that when an investigation of alleged gross negligence is initiated and the case does not fit that criteria, no formal action is taken for acts other than those identified as being

grossly negligent. Since the objective of the investigation is to establish gross negligence, it is unknown how much negligence other than that classified as gross exists. Though we do not know the number of negligent physicians in the State, it remains a fact that we will never know that statistic until a system of recording this information is implemented. The following cases illustrate medical practices that were reviewed and not considered grossly negligent. As a result, no corrective action was mandated by the Board.

In September 1973, two patients, a male age 58 and a female age 70, with chest pains arrived at the same hospital on the same day but at different times. The conditions of the emergency room were crowded and the doctor on duty was not aware that he could call for backup assistance. Both patients were in the emergency room for approximately 30 to 45 minutes and after examination both were sent home. The male was dead one hour after being released from the hospital and the female arrived back in the hospital the following morning -- dead on arrival. The Board requested that an expert review the case and a Director of Emergency Services from another hospital stated the following regarding the 70-year old woman.

> "There is an inadequate history recorded in her chart. Her physical examination appears to have been inadequately done, however, there is grossly inadequate laboratory work ordered, no chest X-ray was ordered, no ECG was taken and depending upon what could have been going on in the Emergency Department at the time she entered, one would have to say that much more could have been done in the work up of the patient."

Regarding the 58-year old man who was brought in by rescue ambulance, the medical expert stated:

> "Overall, again, the history appears to be inadequately recorded. His physical examination appears to be good, and again the lab and X-ray work up is inadequate. This particular patient was in the Emergency Department for not much more than 40 minutes. Again, depending upon what might have been going on in the Emergency Department at the time, I feel that the work up overall is inadequate regardless of whether the patient was considered an asthmatic or a cardiac patient."

The medical expert concluded:

> "Reading the definition of gross negligence, I cannot in good conscience apply it to the physician in question. However, this represents an instance in which the physician is clearly not familiar with adequate cardiac or pulmonary work up in the case of emergency patients."

The medical expert recommended to the Board:

> "As a minimum action in this case, I would strongly recommend that the physician in question be encouraged to stay out of the emergency department or to get adequate training before attempting to take on this kind of responsibility." (Emphasis added.)

The Board has interpreted the law in the above instance as giving it no power to mandate corrective action for the above physician nor having any disciplinary authority over him.

The second example concerns a 1973 complaint from a physician regarding another physician who was delivering between 200 and 250 babies a year in the mother's home. The complaining physician concluded his letter by stating:

> "I can only report this to the...county medical association, and would rely upon your decision as to how best this problem could be approached with the hopeful prevention of a recurrence of this or other problems associated with home deliveries under these circumstances by a physician I believe to be unqualified as an obstetrician, at least under the standards which I believe the American College of Obstetrics and Gynecology and the...county medical association, as well as the California Medical Association represent."

Investigation of the doctors' complaint disclosed the following cases:

a. While examining a patient at her home after inducing labor with tablets, the strength of which he did not know, the patient's membranes ruptured and the umbilical cord prolapsed. The patient's previous pregnancy history indicated a higher than normal rate for complications. The physician's delivery unit did not have emergency equipment. The physician placed the patient in a knee-chest position and she was taken to the hospital in an ambulance where the delivery was performed by another doctor. The child was born with a broken clavicle and was severely depressed at birth.

b. During another examination in a patient's home, the membranes ruptured and the patient was placed in a knee-chest position and rushed to the hospital in the doctor's car. The umbilical cord was prolapsed which caused brain damage to the child, resulting in the child's death. Complications arose in the case because of an incompatible blood type problem and because labor was induced without adequate equipment.

In the above procedure, the doctor was assisted by a woman who was not licensed in California as a nurse or midwife, but was licensed as a midwife in another country.

c. In another case, the physician permitted a woman to deliver at home when she and the father had incompatible blood types, which required a transfusion in a previous birth. He did so stating that he felt the patient was better supervised at home by the husband than in a hospital. Further, the doctor induced labor through pills, the strength of which he did not know.

During the above home deliveries, there was no oxygen or resuscitator equipment present in case of emergency.

In October 1974, a Deputy Attorney General opined that the physician's "...file has been reviewed and there is insufficient evidence to justify disciplinary action". The case was disposed of in August 1975 by a local Regional Compliance Committee (an arm of the Board) recommending but not being able to mandate to the physician in question procedures he could take to prevent the recurrence of the above problems.

Another case in which the Board did not take action concerns a woman who was examined for menopausal symptoms. The physician performed a complete physical examination including taking his own X-rays. The X-rays showed a lesion that the physician thought to be the tip of her rib. The woman was dismissed. A year later the woman returned and it was found that the lesion had not only increased but that it was cancer. The woman, terminally ill, was given a $100,000 settlement as a result of a malpractice suit. The medical consultant stated the following in his report:

> "We had a long talk about this and I told him that in spite of the fact that he had been trained in chest disease that he was taking a certain risk in reading his own films without corroboration by a radiologist. This is not only because he might miss a lesion but also because defensive medicine is very much in order at the present time."

In conclusion, the consultant stated, "We stressed the fact that he should be cautious to keep the number of ordinary negligence cases down and to be careful in handling patients."

In the first and third cases of the above, the Board took no disciplinary action nor enforced remedial action against the physicians because the medical consultants concluded there was no "gross negligence". In the second case, no action was taken because the Attorney General concluded that there was "insufficient evidence to justify disciplinary action".

Disciplinary Committees

Senate Bill 24XX established 14 districts throughout the State, each served by a medical quality review committee. Five members of each district review committee may form a panel to decide a disciplinary case. This panel has the authority to restrict the extent, scope or type of practice of a licensee for a period of one year or less, and to suspend his practice for 30 days or less.

The panel also has the authority to place a licensee on probation which includes requiring the certificate holder to obtain additional professional training and to pass an examination upon the completion of that training. However, the panel does not have the specific authority to determine and record that negligence, other than gross, was a factor in the physician's actions.

Those cases that require more serious disciplinary action are forwarded to the Division of Medical Quality where penalties include revocation of license or suspension for one year.

It should be noted, however, that neither the panel nor the division presently have the specific authority to determine and record for purposes of administrative action acts of negligence other than gross as practiced by physicians. The counsel to the Board of Medical Quality Assurance stated in a letter dated December 8, 1975 that multiple acts of ordinary negligence could, in certain cases, constitute incompetence within the meaning of the Business and Professions Code. Presently, the Board of Medical Quality Assurance does not have an administrative structure that systematically identifies negligence. We found instances where civil negligence was determined by a court of law involving malpractice lawsuits and where no record of the physician's negligence was noted in the Board's files.

CONCLUSION

Present statutes pertaining to "gross negligence" do not protect the public from physician practices that may result in bodily harm or the loss of life. An administrative structure already exists to monitor the quality of medical care in California and to allow for the protection of the public from negligence other than gross if present statutes are amended.

RECOMMENDATION

We recommend that legislation be enacted which defines negligence and empowers the Board to act in cases whereby any act of negligence, gross or otherwise results in bodily harm or the loss of life. We further recommend that such acts be subject to the disciplinary or corrective powers already provided to the Board.

BENEFITS

Implementation of these recommendations should improve the quality of medical care and should over time reduce the instances of medical malpractice within the State.

OTHER PERTINENT INFORMATION

In September 1975, the Legislature created the new Board of Medical Quality Assurance to replace the old Board of Medical Examiners to be effective December 12, 1975. The functions of the old Board and additional new responsibilities are to be administered by the three divisions of the new Board. The new Board consists of 19 members who are divided into the Division of Medical Quality, Licensing and Allied Health Professions. The members of the Board are appointed and assigned to a division by the Governor. Appointments are subject to confirmation of the State Senate. Members of the old Board whose terms have not expired are included as members of the new Board and shall be assigned to a division by the Governor. There are 13 vacancies to be filled in the new Board.

Over four months have elapsed since the passage of AB 1XX and SB 24XX but no appointments to the new Board have been made. Five members of the new Board could have been appointed at any time after expiration of the terms of old members, and held office immediately on the old Board and its successor Board. Two members of the old Board terms expired in June 1974 and three members' terms expired in June 1975. The remaining vacancies on the new Board could have been named after enactment of AB 1XX and SB 24XX in late September 1975 but their appointments would not have been effective until December 12, 1975, the effective date of the legislation.

Nominations for the Board appointments were submitted to the Governor before December 1975.

The Agency Secretaries of Health and Welfare, Agriculture and Services; and the directors of Consumer Affairs and Health urged the Governor in a letter dated November 28, 1975 to appoint the Board of Medical Quality Assurance "as quickly as possible". These officials urged quick appointments by the Governor for several reasons. One reason for the quick appointments was to prevent the old Board from implementing their "unimaginative, status quo proposal" for reorganizing the Board which the above officials believed would result in "a setback in our efforts to dramatically improve the monitoring of medical care".

Legal Problems

In the interim, the old Board is functioning as the new Board and its three divisions until the new Board members are appointed and assigned to a division. The Attorney General stated:

> "Although the matter is not without doubt, where the Governor has not, after December 12, 1975, appointed new members of the Board of Medical Quality Assurance and assigned them to specific divisions adequate to constitute a quorum in a specific division, existing members of the former constituted Board of Medical Examiners may properly handle the work of the board in the three divisions created by the Medical Injury Compensation Reform Act..."

As noted in the Attorney General's opinion, there is some question whether an existing Board member, not designated by the

Governor, may exercise divisional functions. This unclear legal status of an old Board acting as a new one and its divisions could harm the Board's ability to function. Actions of the Board and its divisions are subject to legal challenges in court. For example, discipline imposed by the old Board, acting as the new Board under its Division of Medical Quality, may be challenged in court. If the legality of disciplinary actions are successfully challenged or if disciplinary actions are delayed, unfit physicians could resume their unprofessional medical practice.

A further example of the legal problems created by the failure to appoint a new Board is the effect the operations of the new Board could sustain by not having sufficient revenues to pay the cost of the Board's programs over the next two years. On February 29, 1976, all licenses of physicians and surgeons expire and are invalid, therefore, the licenses must be renewed. The biannual renewal fee provides a substantial portion of revenue needed to support the operations of the Board for a two-year period. The Board and its Division of Licensing, consisting of unassigned members of the old Board, increased the biannual renewal fees by different amounts. The Board increased the renewal fee from $20 to $125 while the Division of Licensing increased the fee to $150. The difference in renewal rates could affect the revenues collected by the Board by approximately $1,950,000. The legal uncertainties of increasing the renewal fees are further confused by which renewal fee should be collected from the licensees.

Delays in Implementation
of AB 1XX and SB 24XX

Failure to appoint a new Board also has delayed the implementation of the reorganization of the Board and hiring new staff to assure the maintenance of high quality medical practices of the Board.

The Agency Secretaries of Health and Welfare, Agriculture and Services requested that the old Board "take no action with respect to recruiting or hiring staff or developing reorganization plans". At the Board meeting of December 12, 1975, the Director of Consumer Affairs requested that no irreversible action be taken until the next meeting of the Board on January 9, 1976.

Respectfully submitted,

Wesley E. Voss
Audit Manager in Charge

February 12, 1976

Staff:

Gerald A. Hawes
Robert J. Maloney
Dore C. Tanner
Thomas P. Callanan
Linda L. Huffman

CLOSING CONFERENCE REMARKS

Department of Consumer Affairs

A closing conference was held with the Director, Chief Deputy and Deputy Director on February 4, 1976. The Department was offered the opportunity to respond formally to the report within a three work-day working period. The Department has declined to respond formally to the report.

Board of Medical Quality Assurance

The Executive Secretary of the Board attended the same closing conference as did the Director of the Department of Consumer Affairs. The Board has declined to respond formally to the report.

Office of the Attorney General

A closing conference was held with three Deputy Attorneys General of the Professional and Vocational Licensing Section of the Office of the Attorney General. Their formal comments on the report are contained on Pages 29 to 34.

EVELLE J. YOUNGER
ATTORNEY GENERAL

STATE OF CALIFORNIA

OFFICE OF THE ATTORNEY GENERAL
Department of Justice
3580 WILSHIRE BLVD.
LOS ANGELES, CALIFORNIA 90010
(213) 620-3175

Mr. Wesley Voss
Audit Manager in Charge
Office of the Auditor General
925 L Street, Suite 750
Sacramento, California 95814

Re: Response to February 1976, Audit of the Board of Medical Quality Assurance and Services Provided that Board by the Office of the Attorney General

Dear Mr. Voss:

The Office of the Attorney General, on behalf of its Professional and Vocational Licensing Administrative Law Section, takes this opportunity to comment on the report of the Office of the Auditor General to the Joint Legislative Audit Committee entitled, "A Review of the Practices of the Board of Medical Quality Assurance and the Services Provided that Board by the Office of the Attorney General," (hereinafter referred to as the "Report"). This response addresses itself first to substantive objections and then to technical errors contained in the Report.

1. For reasons which will become apparent later in this analysis, the first sentence on page 5 of the Report should be changed to read, "The Office of the Attorney General, Professional and Vocational Licensing Section, has not <u>been able</u> to prepare accusations in a timely manner . . . ." Other parallel instances of the construction as it presently appears in the Report should also be changed. Thus, in the Table of Contents, the third line of the first finding should be changed to read, ". . . the Medical Practice Act has not been <u>able to be</u> accomplished . . . ." and in the caption of the finding on page 5, the fourth line should read, ". . . Practice Act has not been <u>able to be</u> accomplished . . . ."

2. The last sentence in the first paragraph on page 5 should be revised inasmuch as it does not fully reflect the reasons for the inability of the Professional and Vocational Licensing Section to prepare accusations in what is considered timely fashion. The mere reference to "inadequate funding" certainly does not fully or fairly explain to the reader the fact that a severe personnel shortage currently exists (and did exist during the period covered by the audit) in the Professional and Vocational Licensing Section, and that because of this understaffing, the Professional and Vocational Licensing Section had to put in an aggregate of over 10,600 hours of uncompensated overtime during the 1974-1975 fiscal year.

The reference in the same sentence to "delays in obtaining additional evidence" also requires amplification. While the phrase correctly implies that additional evidence was necessary in order to prepare accusations, the Report should clearly reflect the fact that most Medical Board cases involving gross negligence and gross incompetence are very complicated ones, necessitating a great deal of expertise, and in part because of that, were evidentially incomplete upon their receipt by this Office. Indeed in an effort to accelerate the disciplinary process, the Deputy Attorney General handling a case often further investigated the case himself in order to file the accusation with greater dispatch.

3.

* * *[1]/

4. The mention, in the first full paragraph on page 6, that "by the time a case reaches the Attorney General, it has been judged by the Board . . . to be of sufficient severity to warrant disciplinary action" is inaccurate. The Board does not and can not participate in the investigatory process, because for it to do so would not enable it to then make an impartial Decision. It is the Board's staff which screens all material concerning investigations before it is transmitted to this Office. The first sentence of the first full paragraph on page 6 should be corrected by inserting the words "staff of the" before the word "Board."

1/Comments deleted refer to items shown in draft report but not included in this report.

5. The reference in the last paragraph on page 6 to the Professional and Vocational Licensing Section having a policy of requiring accusations to be completed within 30 days after their receipt, is no longer accurate. Whereas the 30-day rule was policy in December 1973, it became apparent not long thereafter that it was not practical in light of the failure to increase the Section's staffing to handle the increased volume of cases it was receiving.

6. The reference in the third paragraph on page 8, to this Office's need to obtain additional information/evidence, requires amplification. As written, it implies that only additional minor documentary evidence has been needed to enable this Office to prepare accusations. This has not been the case. Frequently, substantial additional evidentiary material has been needed to prepare (and sustain) a case, which without that additional material, would not have been legally viable.

7.

* * *1/

8. On page 9 (top), the Report discusses the difficulty of obtaining expert witnesses. This discussion might well be amplified to include a discussion of the fact that access to immediate and direct information is blocked by legal prohibitions on obtaining records of admissions of mentally incompetent doctors, and by the refusal of local medical societies and hospital staff committees to make information on their actions against incompetent doctors available to this Office.

9. The first paragraph on page 12, which discusses the relationship of the Board of Medical Quality Assurance and the Attorney General's Office, requires amplification. It notes that the Board has the right to demand that this Office perform the Board's legal services promptly, but that observation perforce assumes that this Office, and more particularly the Professional and Vocational Licensing Section, will be adequately staffed to meet the Board's demands. A sentence should be added to the paragraph to reflect the fact that the Board has a concomitant duty to see that the Attorney General's Office (and the Professional and Vocational Licensing Section) is so adequately staffed.

1/See Comment 1/ on page 30.

10. We disagree with the phraseology of the Conclusion as presently stated on page 12. The Conclusion as stated presumes that the Professional and Vocational Licensing Section of the Attorney General's Office has had the tools available at its disposal to be able to file accusations and it implies that fault in not timely filing those documents has been entirely of its own doing. Clearly this has not been the case. Indeed the first eleven pages of the Report discussed the great handicaps under which the Professional and Vocational Licensing Section has labored in its efforts to prepare accusations in a timely fashion. Accordingly, it is urged that the Report's Conclusion fairly reflect the Report's findings in this regard. This can be done by having the Conclusion read instead, " . . . the Professional and Vocational Licensing Section of the Office of the Attorney General has not been able to prepare accusations against . . . ." As a corollary to this change, as suggested in Item 1 above, the similar phraseology which currently is present in the Table of Contents, the caption on page 5, and the first sentence on page 5, should be changed to a like construction.

11. With respect to the Recommendations on pages 12 and 13 of the Report, i.e., that the Board hire other counsel for administrative proceedings if this Office fails to file accusations within the 30 day limitation provided in AB 1xx: in Item 10 above we expressed the view that the Conclusion on page 12 does neither accurately, fully nor fairly reflect the findings contained in the first eleven pages of the Report. The Recommendations on pages 12 and 13 are similarly inaccurate and they should be revised to discuss other ways of ameliorating inadequacies which the Report has discussed.

12. Pages 16 through 21 of the Report detail three cases as examples of medical practices that were reviewed by the Board and this Office, in which a determination was made that there was no gross negligence. The presentation is misleading. Only the second example was a case which was reviewed by the Professional and Vocational Licensing Section and the Report should, in all fairness, point this out more clearly. The first and last examples given were cases reviewed by Board staff and rejected at that level; as such, they were never transmitted to this Office for our consideration. Further, even in the second case, the delay such as it was, was occasioned at the Board level and the case was rejected by this Office only after two of the Board's Medical Consultants concluded that there was no evidence of gross negligence or gross incompetence. Accordingly, the prefacatory remarks to the

discussion of these cases on page 16 and the conclusionary remarks about them on page 21 should be clarified to categorically explain that this Office had no involvement whatsoever in the first and third cases, and merely followed the advice provided by the Board's expert Medical Consultants in the second. * * *2/

13. In the Appendix on page 28, the compilation of statistics was based solely on cases which involved accusations. It thus ignores other vehicles by which this Office has assisted the Board in limiting or in totally preventing an unworthy physician from practicing. The Professional and Vocational Licensing Section has drafted a number of stipulations (without accusations) wherein a physician has either surrendered his license totally or has agreed to be bound by limitations upon it thus avoiding the accusation. There have also been cases where this Office has assisted the Board by drafting the required document to compel a physician to undergo a psychiatric examination as a result of which, he has thereafter voluntarily surrendered his license to practice. The cases involving these alternatives to formal disciplinary action which this Office has devised, do not appear in the statistics on which the Appendix is based or in the summarization of the Appendix on pages 7 through 8 of the Report. They should be included in any fair and accurate reporting compilation.

The following are technical objections to the content of the Report:

1. It is suggested that the title of the Report be changed to reflect the fact that the Report is actually of a review conducted of the former Board of Medical Examiners. The suggested title should commence, "A Review of the Practices of the Board of Medical Examiners (now Board of Medical Quality Assurance) . . . ."

2. The first paragraph of the introduction on page 1 should be revised to read, "In response to a legislative request, we have reviewed the activities of the former Board of Medical Examiners, now known as the Board of Medical Quality Assurance." This more accurately reflects the true direction of the audit.

3. On page 3, on the sixth line from the bottom of the page, the words "physician" and "surgeon" should be in the possessive, so the phrase should properly read, "physician's and surgeon's certificate."

2/ Clarification made in final report on page 21, however, Attorney General's comments are left for informational purposes.

4. On the second line on page 6, the reference to the "administrative hearing officer" should be changed to "Administrative Law Judge" to correctly use their current title.

5. The last sentence on page 11, is not a correct statement of the law as it existed prior to the effective date of AB 1xx and SB 24xx (December 12, 1975) when the agencies within the Department of Consumer Affairs were all legally required to use the Attorney General as their counsel in all administrative proceedings. SB 24xx has provided a choice of alternate counsel only to the Board of Medical Quality Assurance. * * *3/

Thank you for this opportunity to respond to the Report of the Office of the Auditor General to the Joint Legislative Audit Committee.

Very truly yours,

EVELLE J. YOUNGER
Attorney General

By Lynn Henry Johnson
LYNN HENRY JOHNSON
Assistant Attorney General

3/Legislative Counsel Opinion, attached, as Appendix 2, establishing basis for statement on page 11.

THE NUMBER OF DAYS SPENT ON ALL COMPLETED AND UNCOMPLETED ACCUSATIONS AGAINST PHYSICIANS AND SURGEONS REFERRED TO THE PROFESSIONAL AND VOCATIONAL LICENSING SECTION OF THE ATTORNEY GENERAL'S OFFICE PRIOR TO JULY 1, 1975 AND PENDING AS OF AUGUST 27, 1975

Alleged Violation	Number of Days 0-30	31-60	61-100	101-200	201-400	401-Over	Total
Gross negligence and/or incompetence	1	3		9	12	4	29
Drugs violations	4	9	7	8	12	1	41
Violation of probation from prior disciplinary actions	1	5	3	7	2		18
Self-use of drugs and alcohol	6	9	7	16	9	1	48
Miscellaneous	3	3	5	4	3	1	19
Unlicensed activity	1	4		5	3		13
Gross immorality (with patients)		4	2	5			11
Medically related fraud	3	3	7	4	3		20
Mental illness	1			1		1	3
Cancer quackery	1	1	—	—	1	—	3
Total	21	41	31	59	45	8	205
Percent of Total	10%	20%	15%	29%	22%	4%	100%

BERNARD CZESLA
CHIEF DEPUTY

OWEN K. KUNS
EDWARD K. PURCELL
RAY H. WHITAKER

KENT L. DECHAMBEAU
ERNEST H. KUNZI
STANLEY M. LOURIMORE
SHERWIN C. MACKENZIE, JR.
ANN M. MACKEY
EDWARD F. NOWAK
RUSSELL L. SPARLING
PRINCIPAL DEPUTIES

3021 STATE CAPITOL
SACRAMENTO 95814

107 SOUTH BROADWAY
LOS ANGELES 90012

Legislative Counsel of California

GEORGE H. MURPHY

GERALD ROSS ADAMS
DAVID D. ALVES
MARTIN L. ANDERSON
PAUL ANTILLA
JEFFREY D. ARTHUR
CHARLES C. ASBILL
JAMES L. ASHFORD
JOHN CORZINE
BEN E. DALE
CLINTON J. DEWITT
C. DAVID DICKERSON
FRANCES S. DORBIN
ROBERT CULLEN DUFFY
CARL NED ELDER, JR.
LAWRENCE H. FEIN
JOHN FOSSETTE
HARVEY J. FOSTER
HENRY CLAY FULLER III
ALVIN D. GRESS
ROBERT D. GRONKE
JAMES W. HEINZER
THOMAS R. HEUER
MICHAEL J. KERSTEN
L. DOUGLAS KINNEY
JEAN KLINGENSMITH
VICTOR KOZIELSKI
STEPHEN E. LENZI
DANIEL LOUIS
JAMES A. MARSALA
PETER F. MELNICOE
MIRKO A. MILICEVICH
VERNE L. OLIVER
EUGENE L. PAINE
TRACY O. POWELL, II
MARGUERITE ROTH
HUGH P. SCARAMELLA
MARY SHAW
JOHN T. STUDEBAKER
MARY ANN VILLWOCK
BRIAN L. WALKUP
THOMAS D. WHELAN
JIMMIE WING
CHRISTOPHER ZIRKLE
DEPUTIES

Sacramento, California
May 21, 1975

Honorable Bob Wilson
Assembly Chamber

State Agencies: Representation by Attorney General - #7142

Dear Mr. Wilson:

QUESTION

You have asked if the Department of Consumer Affairs, and it various boards, are required by law to use the Attorney General when preparing accusations and making presentations before a hearing officer when involved in administrative hearings conducted pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

OPINION

The Department of Consumer Affairs, and its various boards, are not required by law to use the Attorney General in the preparation of accusations and presentations made before a hearing officer when involved in administrative hearings conducted pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

ANALYSIS

Section 11042 of the Government Code[1] prohibits state agencies from employing legal counsel other than the Attorney General, or one of his assistants or deputies, in any matter in which the agency is interested. Section 11042 provides:

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[1] All section references, unless otherwise noted, are to the Government Code.

> "11042. No State agency shall employ any legal counsel other than the Attorney General, or one of his assistants or deputies, in any matter in which the agency is interested."

Certain state agencies are exempted from the provisions of Section 11042. Section 11041 provides:

> "11041. Sections 11042 and 11043 are not applicable to the Regents of the University of California, Legal Division of the Department of Public Works, Division of Labor Law Enforcement, Workmen's Compensation Appeals Board, Public Utilities Commission, State Compensation Insurance Fund, Legislative Counsel Bureau, Inheritance Tax Department, Secretary of State, State Lands Commission, Alcoholic Beverage Control Appeals Board (except when the board affirms the decision of the Department of Alcoholic Beverage Control), and Department of Education, nor to any other state agency which by law enacted after Chapter 213, of the Statutes of 1933, is authorized to employ legal counsel."[2]

In addition, Section 11040 expressly provides that the provisions of Section 11042 are not applicable where a state agency has first obtained the written consent of the Attorney General to employ legal counsel.

In the absence of a state agency being exempted pursuant to Section 11041 or obtaining the consent of the Attorney General pursuant to the provisions of Section 11040, the provisions of Section 11042 would prohibit a state agency from employing any legal counsel.

Whether an individual employed by a state agency is employed in the capacity of "legal counsel" within the meaning of the term as used in Section 11042 of the Government Code would, we think, be dependent upon the nature of the duties and functions performed by such individual.

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[2] We have not in this opinion considered the extent to which any of the various boards comprising the Department of Consumer Affairs are authorized by law enacted after Chapter 213, of the Statutes of 1933, to employ legal counsel and are thus exempted from the provisions of Section 11042.

With respect to accusations prepared pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code, Section 11503 specifies the nature of their contents and expressly provides that shall be verified unless made by a public officer acting in his official capacity or by an employee of the agency before which the proceeding is to be held. There is no requirement that they be prepared by an officer or employee that is an attorney or one who is acting in a capacity of legal counsel for the agency. Section 11503 provides:

> "11503. A hearing to determine whether a right, authority, license or privilege should be revoked, suspended, limited or conditioned shall be initiated by filing an accusation. The accusation shall be a written statement of charges which shall set forth in ordinary and concise language the acts or omissions with which the respondent is charged, to the end that the respondent will be able to prepare his defense. It shall specify the statutes and rules which the respondent is alleged to have violated, but shall not consist merely of charges phrased in the language of such statutes and rules. The accusation shall be verified unless made by a public officer acting in his official capacity or by an employee of the agency before which the proceeding is to be held. The verification may be on information and belief." (Emphasis added.)

We think that in view of the nature of the contents of an accusation as requred in Section 11503 and the express provisions authorizing a public officer or employee of the agency to prepare an accusation, that an employee preparing an accusation pursuant to Section 11503 would not be employed in the capacity of legal counsel.

With respect to presentations made by an agency before the hearing officer, Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code contains no provisions requiring that the presentations be made by one with legal training or one who is a legal counsel.

With respect to the conduct of such hearings, subdivision (c) of Section 11513 expressly provides that they need not be conducted according to technical rules relating to evidence and witnesses and that any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs. Subdivision (c) of Section 11513 provides:

> "(c) The hearing need not be conducted according to technical rules relating to evidence and witnesses. Any relevant evidence shall be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the existence of any common law or statutory rule which might make improper the admission of such evidence over objection in civil actions. Hearsay evidence may be used for the purpose of supplementing or explaining other evidence but shall not be sufficient in itself to support a finding unless it would be admissible over objection in civil actions. The rules of privilege shall be effective to the extent that they are otherwise required by statute to be recognized at the hearing, and irrelevant and unduly repetitious evidence shall be excluded."

In view of the permissive informality and absence of the requirement of technical rules of law relating to evidence and witnesses at such hearings, we think, that the nature of the hearing is such that one making a presentation to a hearing officer of such a hearing would not be required to be made by one who is employed in the capacity of legal counsel.

Thus, we conclude that the Department of Consumer Affairs, and it various boards, are not required by law to use the Attorney General in the preparation of accusations and presentations made before a hearing officer in administrative hearings conducted pursuant to the provisions of Chapter 5 (commencing with Section 11500) of Part 1 of Division 3 of Title 2 of the Government Code.

Very truly yours,

George H. Murphy
Legislative Counsel

By
Carl Ned Elder, Jr.
Deputy Legislative Counsel

CNE:kd

cc: Members of the Legislature
Office of the Governor
Office of the Lieutenant Governor
Secretary of State
State Controller
State Treasurer
Legislative Analyst
Director of Finance
Assembly Office of Research
Senate Office of Research
Assembly Majority/Minority Consultants
Senate Majority/Minority Consultants
California State Department Heads
Capitol Press Corps